Proposed name of facility/agency/clinic

APPLICANT INFORMATION FOR SNFs, ICFs, ICF/DDHs, ICF/DDNs, AND CLINICS

This form is intended for the following:

1. Any individual owning an applicant facility;
2. Each partner, each director, each officer of a corporation;
3. Each manager, each member of a limited liability company;
4. Each administrator of a Primary Care Clinic (PCC);
5. Each person having a beneficial interest of at least 5 percent or more in the applicant corporation, applicant limited liability company, applicant partnership, or applicant management company of a SNF or ICF.

In addition to completion as part of an application package, this HS 215 A form should be completed for disclosure purposes when changes are reported in officers, directors, purchase of stock, etc., as required by law, **even though no change of ownership is occurring.**

A. Identifying Information [H&S 1212, 1265, and 1267]

Name	Date of birth		
Business address (number, street, apartment/suite number or letter if applicable)	**City**	**State**	**ZIP code**
Title in relation to this facility	**If administrator, list hours spent at each clinic per week.**		
Have you applied for ANY license for a health facility or community care facility regardless of your role or title using any name? If yes, list all other names.	**Spouse's name if spouse has a financial interest in this entity and/or other entities that are licensed (please see Section B below)**		

B. Facility, Agency, Clinic Involvement (In or out of California) [H&S 1212, 1253, 1265 and 1267]

1. Have you served in any health facility, agency, or clinic as a/an:
   ☐ Director ☐ Licensee ☐ Manager ☐ Member ☐ Officer ☐ Owner ☐ Partner ☐ Shareholder
   ☐ Other capacity, please specify: _____
2. Have you ever operated or managed (including management agreements) a:
   ☐ SNF ☐ ICF ☐ Community Care Facility ☐ Residential Care Facility for the Elderly
   ☐ Other capacity, please specify: _____
3. Have you ever held a 5 percent or more beneficial ownership interest in a:
   ☐ SNF ☐ ICF ☐ Residential Care Facility for the Elderly ☐ Community Care Facility
   ☐ Other ownership interest, please specify: _____
4. Have you ever held a 10 percent ownership interest in any other facility category, such as:
   ☐ ICF/DD ☐ ICF/DD-H ☐ ICF/DD-N ☐ Clinic ☐ General Acute Care Hospital ☐ Home Health Agency
   ☐ Other ownership interest, please specify: _____
5. Have you ever been involved in one or more of the following business entities that operated health or community care facilities:
   ☐ Corporation ☐ Individual ☐ Limited liability company ☐ Management company ☐ Partnership
   ☐ Other capacity, please specify: _____

- If you have checked any of the boxes in Section B, the following information and completion of Section C is required [H&S 1253 and 1267]. Please attach additional pages if necessary.

Facility name	Percent of involvement *(optional)*	Federal tax ID number (optional)	
Facility address (number, street)	**City**	**State**	**ZIP code**

C. Adverse Actions [H&S 1265 and 1267]

Did any of the following adverse actions take place while you served in any of the capacities checked in Section B?

☐ Had a final Medi-Cal decertification action taken ☐ Placed on probation ☐ Receiver appointed
☐ Resolved by settlement ☐ Revocation action filed ☐ Revoked (whether stayed or not) ☐ Suspended

If yes, please provide additional information: _____

D. Criminal Record [H&S 1265]

1. Have you ever been convicted of an offense that is still on your record, whether misdemeanor or felony? ☐ Yes ☐ No
2. Has there been a judgment against you for Medicare or Medicaid (Medi-Cal) fraud or by a health care professional/technical licensing entity? ☐ Yes ☐ No

   If yes, please provide additional information:

   _____

E. Employment/Business Summary (for last 10 years). Please list any additional experience that qualifies you to operate this type of facility. Attach additional pages if necessary [H&S 1212, and 1267].

Date	Name and Address of Employer(s)	Job Title
From:		
To:		
From:		
To:		
From:		
To:		

F. Professional Licenses/Certificates. This requirement is mandatory for Primary Care Clinics and optional for health facility types [H&S 1212].

Type	Period Held	Issuing Agency

I declare under penalty of perjury that the statements on this form and any accompanying attachments are correct to the best of my knowledge.

Signature _____ Date _____

Release of Information Statement

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the California Department of Health Services, Licensing and Certification, in accordance with Health and Safety Code, Sections 1212, 1253, 1265, 1267.5, and 1278.

Failure to provide the information as requested may result in nonissuance of a license or license revocation.

The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.